MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2003

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004-2616

NAIC Group Code 0429
NAIC Company Code 64246

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004-2616

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2003

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

November 18, 2004

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of The Guardian Life Insurance Company of America was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 7 Hanover Square, New York, NY 10004-2616. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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COMPANY PROFILE

The Company is licensed in all fifty (50) states and the District of Columbia, and received its Certificate of Authority to operate in Colorado on December 10, 1913.

Guardian has a small presence in the Colorado small group market. The Company started as an Indemnity carrier but as it introduced a PPO – Private Healthcare Systems (PHCS) in the market, most of its business converted to this product.

Below is a three-year history of Guardian's small group block of business in the state:

Year	Groups	Covered Lives	Premium
2001	144	2,141	$ 5,290,910
2002	259	3,951	$ 10,131,679
2003	290	4,019	$ 11,653,711

Most of Guardian's business over the past three years has been under the PHCS PPO product. Over 90% of covered lives have been under a PPO plan over the last three years as shown in the table below.

Year	Indemnity Lives	PPO Lives	Total Lives	PPO Lives as a % of Total Lives
2001	81	2,060	2,141	96.2%
2002	67	3,884	3,951	98.3%
2003	56	3,963	4,019	98.6%

At the beginning of 2003, Guardian started losing quite a number of lives in the small group market. This was due to a combination of employers seeking cheaper health plans and a stronger network. During the third quarter of 2003, the Company introduced Sloans Lake as another PPO network in the market. Sloans Lake has a strong local presence and Guardian feels this will significantly increase market share. High deductible plans are being actively marketed in order to reduce premium costs for the employers. An increase in new business activity was seen towards the end of 2003 and for the first time in recent years, the Company's new business sales started to outpace its lapse rate in the Colorado small group market. As of July 1, 2004, Guardian had over 8,000 small group covered lives.

The Company's 2003 direct written premium for accident and health plans in Colorado was $48,890,000 representing 2.06% of the market share.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Guardian Life Insurance Company of America. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to small group sickness and accident insurance laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The limited examination included review of the following:

Policy Forms
Claims

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

For the period under examination, the examiners included statutory citations and regulatory references related to small group insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices

of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-124	Prescription information cards – legislative declaration
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Emergency Regulation 03-E-3	Concerning the Basic Health Benefit Plan
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Regulation 1-1-7	Market Conduct Record Retention
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
New Regulation 4-2-	External Review of Benefit Denials of Health Coverage Plans

21	
Repealed and Repromulgated Regulation 4-6-2	Group Coordination Of Benefits
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Amended Regulation: 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations

Policy Forms

The examiners reviewed the following Policy Forms, Application, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
CGP-3-CO-BP-et al	Preferred Provider Organization Basic Health Benefit Plan
CGP-3-CO-SP-et al	Preferred Provider Organization Standard Health Benefit Plan
CGP-3-CO-BI-et al	Indemnity Basic Health Benefit Plan
CGP-3-CO-SI-et al	Indemnity Standard Health Benefit Plan
CGP-3-R-CHS-CO-95	Major Medical PPO Plan
None	Health Benefit Plan Description Forms 1. Plan Type 4V-Most Frequently Sold Plan 2. Basic PPO Plan 3. Standard PPO Plan 4. Basic Indemnity Plan 5. Standard Indemnity Plan
HC-P-85	1. Basic PPO Conversion Plan 2. Standard PPO Conversion Plan 3. Basic Indemnity Conversion Plan 4. Standard Indemnity Conversion Plan
HC-R-HIPAA-97	Policy Rider
HC-R-BABY-CO-97	Policy Rider
HC-R-DBT-CO-98	Colorado Policy Rider
HC-R-CO-DEF-94	Colorado Policy Rider
HC-R-PREG-01-CO	Colorado Policy Rider
HC-P-PD-CO-01-BS	Colorado Policy Rider
HC-R-STAT-CO-01	Colorado Policy Rider

HC-R-POB-CO-02	Colorado Policy Rider
HC-R-IED-CO-02	Colorado Policy Rider
HC-R-STAT-CO-02	Colorado Policy Rider
HC-R-CO-PPOB-95-1	Colorado Policy Rider
HC-R-CO-PPOS-95-2	Colorado Policy Rider
GG-010702CO	Specifications For A Plan of Group Insurance (For Less Than 10 Lives) (Application)
GG-012638CO	Specifications For A Plan Of Group Insurance (Application)
GG-011460-CO	Supplement to Specifications For A Plan of Group Insurance - Colorado
GG-695-CO (4/96)	Health Statement Colorado
HC-A-85 (3/00)	Application for Group Converted Major Medical Policy
HC-A-CO-PPO-95	Colorado Supplemental Application for Policy HC-P-85
8036	Prescription Drug Card
GG-982CO	Refusal of Group Insurance

The most frequently sold individual plan in Colorado in 2003 was the Major Medical PPO Plan, Form No. CGP-3-R-CHS-CO-95.

Claims

The examiners used ACL™ software to randomly select samples of electronically received and non-electronically received small group claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL™ software to randomly select samples of one hundred Paid claims and fifty (50) Denied claims that were reviewed for the Company's overall claims handling practices. Upon review, one (1) of the denied claims was determined to not be a Colorado claim; therefore, the sample of fifty (50) Denied claims was reduced to forty-nine (49). These claims were all received during the examination period of January 1, 2003 through December 31, 2003.

After the sampling and review process had been completed, the Company discovered that an error existed within the paid and denied claims program logic. This error caused some claims to be included in the original data provided that were not Colorado sitused group plans and additionally some Colorado claims that should have been captured were omitted. The Company provided a written statement that the samples and findings from the original data that it provided were acceptable and an accurate representation of their claim handling.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-three (33) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Policy Forms:** The examiners found twenty-nine (29) areas of concern in their review of the Basic and Standard state mandated plans and the most frequently sold small group policy forms in use during the year under examination. The following issues were identified:

    1. Failure to submit an Annual Report and Certification of Forms in use or available for use in 2003.

    2. Failure to reflect correct benefits for durable medical equipment in the Basic and Standard Health Benefit Plans.

    3. Failure to reflect one of the mandatory fields on the Prescription Drug Card.

    4. Failure to modify the Basic Health Benefit Plan or offer a rider to exclude certain benefits from July 1, 2003 until January 1, 2004.

    5. Failure to reflect correct coverage to be provided for inpatient well baby care.

    6. Failure to reflect correct benefits for preventive child health supervision services. (This was a prior issue included in E9 in the findings of the 2000 final examination report).

    7. Failure to reflect a correct definition of a dependent. (This was a prior issue included in E24 in the findings of the 2000 final examination report).

    8. Failure to offer the opportunity to purchase benefits for alcohol and substance abuse in the Basic and Standard Health Benefit Plans.

    9. Failure to reflect correct preventive services in the Basic and Standard Health Benefit Plans.

    10. Failure to reflect correctly the extent of coverage for home health services and hospice care. (This was a prior issue included in E12 in the findings of the 2000 final examination report).

    11. Failure to reflect correct coverages for maternity benefits and complications of pregnancy.

    12. Failure to reflect correct coverage provisions for skilled nursing facility care. (This was a prior issue included in E13 in the findings of the 2000 final examination report).

    13. Failure to reflect the coverage to be provided for inherited enzymatic disorders.

14. Failure to reflect all or reflect completely some required small group provisions.

15. Failure to reflect a complying provision regarding network adequacy.

16. Failure to reflect correct coverages for physical, occupational and speech therapy in the Basic and Standard Health Benefit Plans.

17. Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member or a business or professional associate of the member or their family.

18. Failure to reflect correct provisions for conversion and continuation privileges.

19. Failure to prominently display the required small group disclosure statement on small employer applications. (This was prior issue E1 in the findings of the 2000 final examination report).

20. Failure to reflect correct group coordination of benefit provisions.

21. Failure to correctly define the requirements to qualify as an eligible employee. (This was prior issue E18 in the findings of the 2000 final examination report).

22. Failure to provide coverage for spinal manipulation in the Basic and Standard Health Benefit Plans.

23. Failure to reflect the correct number of days to be allowed for a break in coverage.

24. Failure to reflect the correct maximum combined period of exclusion of coverage and preexisting conditions for late enrollees.

25. Failure to display a fraud warning that is substantially the same as required by law. (This was prior issue E15 in the findings of the 2000 final examination report).

26. Failure to reflect correct information in a conversion plan application concerning issuance of conversion coverage.

27. Failure to use the exact required format or to correctly represent the benefits, conditions, or terms of coverage in Health Benefit Plan Description Forms.

28. Failure to include all health insurance forms in use on the 2003 annual forms report. (This was prior issue E2 in the findings of the 2000 final examination report).

29. Certifying and using forms that, in some cases, do not comply with Colorado insurance law. (This was prior issue A2 in the findings of the 2000 final examination report).

It is recommended that the Company review and revise all applicable policy forms to ensure compliance with all requirements of Colorado insurance law.

- **Claims:** The examiners found four (4) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    1. Failure in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law. (This was prior issue J1 in the findings of the 2000 final examination report).

    2. Failure to follow correct procedure for denial of benefits.

    3. Failure to accurately determine the number of days utilized for claim processing.

    4. Failure to pay and/or correctly calculate applicable late payment interest/penalty in some cases. (This was prior issue J2 in the findings of the 2000 final examination report).

    It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time periods required by law. Additionally, procedures should be established to ensure that the number of days utilized for claim processing is calculated correctly, that late payment interest and penalties are paid in all applicable instances, and claim procedures should be reviewed to ensure accuracy of benefit payments in all cases.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to submit an Annual Report and Certification of Forms in use or available for use in 2003.

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to §§ 10-1-109, 10-4-419, 10-4-725, 10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states:

> Section 2. Purpose
>
> The purpose of this regulation is to promulgate rules applicable to filing of new policy form listings, annual reports of policy forms, and certifications of policy forms.
>
> Section 4. Definitions
>
> For the purposes of this regulation:
>
> D. "Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.

Section 5. Rules

C. Not later than December 31 of each year, each entity providing health care coverages shall file an Annual Report of policy forms including a fully executed certificate of compliance. …

Bulletin 9-00, Requirements for the Filing of Rates, Rules, and Forms for All Insurance Companies, effective August 3, 2000, states:

Section 1. Background and Purpose

The purpose of this Bulletin is to provide companies with comprehensive guidance on filing insurance rates, rules, and forms. This Bulletin replaces in its entirety Bulletin 9-99. Following these guidelines will reduce or eliminate incomplete or unsupported rate, rule, loss cost, and form filings, while providing greater protection to Colorado consumers. This Bulletin provides a standardized format for the certification of the forms as prescribed in Colorado Regulation 1-1-6, for each Listing of New Policy Forms or Annual Report of Policy Forms, and requires that health coverage compliance guides remain on file with the insurer. Additionally, the submission of a complete and supported filing should reduce costs to the insurance industry, Colorado consumers, and the Division of Insurance.

Section 3. Action Necessary

All Filings

… Given this requirement, the duplicate filing, stamped by the Division of Insurance and returned to the company, is a necessary record that should be maintained by the company. These records may be requested as part of an investigation of an insurance complaint, a rate investigation, a desk audit, or a market conduct examination.

Companies must submit all filings in duplicate with a self-addressed, postage-paid envelope large enough to accommodate the return filing. The duplicate filing will be returned to the company in order to acknowledge filings received by the Division of Insurance, and it must be a duplicate copy of the entire filing (not just the cover letter). If a duplicate copy, postage-paid envelope of a sufficient size to accommodate the filing, or minimum supporting documentation is not received, the filing will be returned as incomplete.

Colorado insurance law requires an Annual Report to the Commissioner listing any policy form, endorsement, rider or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted no later than December 31 of each year, in duplicate, in order that the Division of Insurance may acknowledge the filing.

A cover letter, dated January 23, 2004, was submitted to the Colorado Division of Insurance that referenced new forms and the listing indicating an annual filing. However, no certification or duplicate copy was provided to the Division of Insurance and the filing was returned to Guardian on February 12, 2004 as incomplete. There is no record of the resubmission of this Annual Report and the Company was unable to provide a copy of a dated and stamped Annual Report of Certification of Forms in use or available for use in Colorado during 2003.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S. and Amended Regulation 1-1-6. In the event the Company is unable to show such proof it should provide evidence to the Division of Insurance that it has established procedures to ensure that an Annual Report and Certification of Forms is filed as required by Colorado insurance law.

Issue E2: Failure to reflect correct benefits for durable medical equipment in the Basic and Standard Health Benefit Plans.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. secs. 1395K, 13951, and 1395m and 42 CFR 414.202, 414.210, 414.228 and 410.100, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) *Repairs and replacements of prosthetic devices are also covered*, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added]

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

III. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

	BASIC AND STANDARD PREFERRED PROVIDER PLANS IN-NETWORK OUT-OF-NETWORK [1a]
22. DURABLE MEDICAL EQUIPMENT [21]	50% up to maximum $800/year paid by plan.

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	STANDARD INDEMNITY PLAN
22. DURABLE MEDICAL EQUIPMENT [21]	50% up to maximum $800/year paid by plan.	50% up to maximum $800/year paid by plan.

21. Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is not covered.

The description of coverage for Durable Medical Equipment in the Company's Basic and Standard PPO and Indemnity Health Benefit Plans appears to be more limiting than is allowed by Colorado insurance law in the following ways:

1. Nothing is reflected to indicate that repairs and replacement needed because of normal usage of prosthetic devices (to be included under this category) are to be covered.

2. Nothing is reflected to indicate that the cost of prosthetic devices for arms or legs or any parts thereof are not subject to the annual DME cap.

3. Nothing is reflected to indicate that coverage is to be provided under this category for the lesser of purchase or rental price for home-administered oxygen.

The wording in the Basic and Standard PPO and Indemnity Health Benefit Plans is as follows:

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PART II – SUMMARY OF BENEFITS

Medical Expense Coverage

Durable Medical Equipment $800/year

Page 10

Comprehensive Medical – Summary of Benefits

SERVICE	PREFERRED PROVIDER	OTHER THAN PREFERRED PROVIDER
Category C – Durable Medical Equipment and Outpatient Prescription Drugs		
Coinsurance %	50%	50%

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PART IV – DESCRIPTION OF BENEFITS

Section B – Comprehensive Medical

Covered Charges

Category C includes:

(2) the lesser of the rental or purchase of medically necessary durable medical equipment up to a maximum benefit of $800 for each insured person each calendar year.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof it should provide evidence to the Division of Insurance that it has revised its Basic and Standard Health Benefit Plans to reflect correct benefits for durable medical equipment as required by Colorado insurance law.

Issue E3: Failure to reflect one of the mandatory fields on the prescription drug card.

Section 10-16-124, C.R.S., Prescription information cards – legislative declaration, states:

> (2) Each health benefit plan that offers coverage for prescription drugs shall issue to the named insured a card or other device containing uniform prescription drug information. Such card or device shall be in the format approved by the national council for prescription drug programs, *shall include all of the required and situational fields* and shall conform to the most recent pharmacy identification card or device implementation guide produced by the national council for prescription drug programs. [Emphasis added]

Bulletin 04-02, Standardized Format for Prescription Drug Cards, states:

> I. Background and Purpose
>
> The 2002 Colorado General Assembly enacted legislation that requires health benefit plans that provide coverage for prescription drugs to issue a card or device with uniform prescription drug information to the named insured or enrollee. [See § 10-16-124, Colorado Revised Statutes.] The statute specifies that the card shall be in the format approved by the National Council for Prescription Drug Programs (NCPDP). This bulletin provides drug card format information from NCPDP.
>
> II. Applicability
>
> The NCPDP standardized drug card format shall be utilized by any health benefit plan, issued or renewed on or after January 1, 2003, that provides prescription drug coverage, except for health benefit plans issued by an HMO that supplies its enrollees with prescription drugs from an in-house drug or pharmacy outlet.
>
> III. Standardized Prescription Drug Card Format
>
> Appendix A reflects the NCPDP standardized prescription drug card format.

Appendix A

NCPDP Pharmacy ID Card Fact Sheet

This Fact Sheet relates to the current NCPDP Health Care Identification Card Pharmacy ID Card Implementation Guide ("The Guide"). The purpose of The Guide is to reduce the time that consumers wait for prescriptions at community retail pharmacies by preventing delays caused by the lack of necessary information on consumer prescription benefit ID cards.

The Guide requires the minimum necessary information that must be included and lists additional information that may be included in specific situations. [Emphasis added.] …

Mandatory Information

Back of card:

6. **Name and address of the benefit administrator** where non-electronic prescription claims, patient, or provider correspondence can be sent.

The Company's prescription drug card used with the most frequently sold plan in Colorado in 2003 does not appear to have one of the mandatory fields (No. 6) for the back of the card. There is no name and address of the benefit administrator reflected.

The back of the Prescription Drug Card reflects the following:

Members

This card must be presented at a participating pharmacy when purchasing prescription drugs.

To locate a participating pharmacy, or for more information about your prescription benefit plan, please visit our website at www.medcohealth.com or call Member Services at 1-800-417-1783.

Pharmacists, Submit claims via the TelePAID@System only for the person for whom the prescription was written. Dispense preferred cobranded and generic drug products where applicable in accordance with prevailing pharmacy laws and regulations. For more information contact the Pharmacy Services Help Desk at 1 800 922-1557 or visit the Pharmacist Resource Center at www.medcohealth.com/rph.

Form Number	Form Name
NV	Major Medical PPO Prescription Drug Card

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-124, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its prescription drug card to reflect all required information as required by Colorado insurance law.

Issue E4: Failure to modify the Basic Health Benefit Plan or offer a rider to exclude certain benefits from July 1, 2003 until January 1, 2004.

Amended Emergency Regulation 03-E-3, Concerning the Basic Health Benefit Plan, promulgated under the authority of Sections 10-1-109, 10-16-109, and 10-16-105(7.2), C.R.S., states:

> Section 2 Purpose
>
> Effective January 1, 2004, Regulation 4-6-5 will be amended to provide for changes to the Basic and Standard Health Benefit Plans, including the elimination of specified mandates in the Basic Plan. The purpose of this emergency regulation is to provide, in the interim, for the option of a basic plan that does not include the mandatory coverage provisions of 10-16-104(4), (5), (8), (9), (10), and (12), C.R.S., pursuant to the newly enacted statutory provision in Section 10-16-105(15), C.R.S.
>
> Section 3 Rules
>
> Effective July 1, 2003, and until January 1, 2004, small group carriers shall modify the Basic Health Benefit Plan, or offer a rider to the Basic Health Benefit Plan, to exclude benefits as specified in the mandatory coverage provisions of Sections 10-16-104(4), (5), (8), (9), (10), and (12), C.R.S. An offer of an exclusion rider shall include disclosure of the premium discount the employer would receive by accepting the rider.
>
> Section 6 Effective Date
>
> This emergency regulation is effective on July 1, 2003, and amendments are effective on July 31, 2003.

It does not appear that the Company is in compliance with Colorado insurance law as the requirement to modify the Basic Health Benefit Plan to exclude specified coverages was mandatory, not an option. The only option was whether the plan itself was modified or if the modifications were accomplished via a rider. The Company's response to the examiner's question as to which method was used to comply with the requirements of Amended Emergency Regulation 03-E-3 indicates Guardian did not elect to offer an exclusionary rider and did not modify the Basic Health Benefit Plan until new plan designs were mailed out with a letter dated April 2004.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Emergency Regulation 03-E-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has modified its Basic Health Benefit Plans to exclude specified coverages as required by Colorado insurance law.

Issue E5: Failure to reflect correct coverage to be provided for inpatient well baby care in the Basic and Standard Health Benefit Plans.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: PREFERRED PROVIDER
2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY

PART B: SUMMARY OF BENEFITS

	BASIC PREFERRED PROVIDER PLANS	
	IN-NETWORK	OUT-OF-NETWORK [1a]
10. MATERNITY a) Prenatal	70% (deductible does not apply)	50% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	70%	50%

	STANDARD PREFERRED PROVIDER PLANS	
	IN-NETWORK	OUT-OF-NETWORK [1a]
10. MATERNITY a) Prenatal	80% (deductible does not apply)	50% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	80%	50%

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	STANDARD INDEMNITY PLAN
10. MATERNITY a) Prenatal	50% (deductible does not apply)	70% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	50%	70%

7 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

The Company's Basic and Standard Health Benefit Plans reflect incorrectly that there is a $10.00 copay for a well baby newborn pediatric examination and do not appear to reflect that an in-hospital newborn hearing screening is to be covered under well baby care.

The wording in the plans is as follows:

Page 32

PART IV – DESCRIPTION OF BENEFITS

Section B – Comprehensive Medical

Obstetrical Care and Family Planning

A newborn shall also be eligible for a well baby newborn pediatric examination subject to the $10.00 copay described under "Preventive Care".

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Basic and Standard Health Benefit Plans to reflect correct coverage information for inpatient well baby care as required by Colorado insurance law.

Issue E6: Failure to reflect correct benefits for preventive child health supervision services.
(Cited items 2 and 3 were prior issue E9 in the findings of the 2000 final examination report)

Section 10-16-104, C.R. S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services. …

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

9. PREVENTIVE CARE (deductible does not apply) [6] (a) Children's services (b) Adults' services

6 See Attachment 1 for list of covered preventive services

Attachment 1

COVERED PREVENTIVE SERVICES	
All Children	Immunization deficient children are not bound by "recommended ages" on immunization chart
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
Age 13-35 months	2 well-child visits

The benefits for child health supervision services reflected in the Company's most frequently sold plan in Colorado do not appear to be in compliance with the requirements of Colorado insurance law in the following ways:

1. Nothing is reflected to indicate that immunization deficient children are not bound by "recommended ages" on the immunization chart.

2. Nothing is reflected to indicate that coverage is provided for one (1) newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery. Additionally, this coverage appears to be excluded by a statement under "Benefits for a Covered Newborn Child."

3. The description of covered preventive services for age grouping "13 months through 24 months" should be through 35 months.

The wording in the plan is as follows:

Pages 49 and 50

Covered Charges (Cont.)

Child Health Supervision

Services We pay benefits for *covered charges* for child health supervision services provided to a *covered dependent* child from birth through age 12. This *plan's* deductible and payment limit provisions will not apply to such charges. But, what we pay is based on all of the terms of this *plan* and is subject to the following limitations.

We pay benefits for:

- Covered immunizations recommended by the American Academy of Pediatrics for all children from birth through age 12
- 5 Well Child Visits and 1 PKU for children from birth through 12 months of age
- 2 Well Child Visits for children age 13 months through 24 months
- 3 Well Child Visits for children age 3 years through 6 years
- 3 Well Child Visits for children age 7 years through 12 years

The child health supervision services must be provided by or under the supervision of a *doctor* or by a primary health care provider who is a physician's assistant or a registered *nurse* with additional training in child health assessment. Child health supervision services provided during a periodic review shall only be covered to the extent that such services are provided during the course of one visit.

Unless this *plan* provides specific benefits, we do not cover any other charges for routine, preventive or diagnostic services.

Page 55

Charges Covered With Special Limitations (Cont.)

Benefits For A Covered Newborn Child

… And we cover charges for the child's routine nursery care while he or she is in the *hospital*. This includes: (a) nursery charges; (b) charges for routine *doctor's* examinations and tests; and (c) charges for routine procedures, like circumcision. But, unless this *plan* provides specific benefits, we don't pay for the routine care of the child once he leaves the *hospital*.

Form Number	Form Name
Form No. CGP-3-CC et al	Major Medical PPO Plan

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its plans to reflect correct benefits for preventive child health supervision services as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to correctly or completely describe preventive services for a newborn and the age grouping of thirteen (13) months to thirty-five (35) months. The violation resulted in Recommendation # 16, that the Company establish procedures to ensure that covered preventive services are correctly reflected in its forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E7: Failure to reflect a correct definition of a dependent. (Item 4 cited for the Conversion Plans was prior issue E24 in the findings of the 2000 final examination report)

Section 10-16-102, C.R.S., Definitions, states:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and *an unmarried child of any age who is medically certified as disabled and dependent upon the parent*. [Emphasis added.]

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (6.5) Adopted child – dependent coverage
>
> (a) Whenever an entity described in paragraph (a) of subsection (6) of this section offers coverage for dependent children under a health plan, the entity shall provide benefits to a child placed for adoption with an enrollee, policyholder, or subscriber under the same terms and conditions that apply to a natural dependent of an enrollee, policyholder, or subscriber, *regardless of whether adoption of the child is final*. [Emphasis added.]
>
> (c) For the purposes of this subsection (6.5), unless the context otherwise requires:
>
> (I) "Child" means a person who has not attained eighteen years of age.
>
> (II) "Placed for adoption" means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption.
> …

1. The Company's Basic and Standard Health Benefit Plans do not appear to be in compliance with Colorado insurance law that defines a disabled dependent as being medically certified as disabled and dependent upon the parent. A dependent that is medically certified as disabled cannot have the limiting condition attached of being dependent for "primary" support on the insured parent.

The wording in the Basic and Standard Health Benefit Plans is as follows:

Page 18

> **Termination**
> Insurance for all of your Dependents will terminate on the earliest of:
>
> However, Medical Expense Insurance will be continued beyond the maximum age for a Dependent child who is incapable of self-support because of Developmental Disability or Physical Handicap *and is dependent on you for primary support*. [Emphasis added.] You must apply for this continuation within 31 days after the child reaches the maximum age.

The Conversion Plans used by the Company do not appear to reflect a correct definition of a dependent in the following ways:

1. Colorado insurance law defines a disabled dependent as being medically certified as disabled and dependent upon the parent. A dependent that is medically certified as disabled cannot have the limiting condition attached of being "wholly" dependent for support on the insured parent.

2. Colorado insurance law does not require that a disabled dependent qualify as such prior to age 19.

3. Colorado insurance law defines a child for purposes of adding an adopted child as a dependent for coverage, as a person who has not attained eighteen years of age.

4. Colorado insurance law does not require an adoption to be final or that an adopted child join an insured's household for the child to be eligible for coverage. Adopted children are eligible for coverage when "placed" for adoption (a legal obligation in anticipation of the adoption) rather than at the point when the child is actually placed in the home.

5. Colorado insurance law does not allow the Basic and Standard Health Benefit Plans to be more liberal than what is reflected in the statutes regarding the ages when children cease to be eligible for coverage as a dependent.

The wording in the plans is as follows:

Page five

> **Covered persons**
>
> The persons named in the schedule page and any persons who are added to coverage while your policy is in force are covered persons, unless their covered status has ended as set out below.
>
> A special child is an unmarried child *who depends wholly on you for support*; who is incapable of self-sustaining employment; and *who became so incapable before age 19*, by reason of mental illness, developmental disability, mental retardation, or physical handicap. [Emphases added.]

Adding covered persons

While your policy is in force, you may add the following persons to coverage:

- a new spouse;
- a child born to you;
- a child *age 19* whom you adopt or who becomes dependent on you; [Emphasis added.]
- a new stepchild under age 19;
- a special child, of any age;

Such persons will be covered without charge *from the date each joins your household* to the first premium due date that falls at least 60 days later. …[Emphasis added.]

End of covered person status

A child will cease to be a covered person on the first policy anniversary after such child becomes *age 23* or, if earlier, after the date such child marries. But, an unmarried child, who is a full time student, may continue under this policy until the first policy anniversary after such child becomes *age 25.* [Emphases added.]

A special child may continue as a covered person after *age 23*. … [Emphasis added.]

The wording in a Colorado Policy Rider is as follows:

Page P660.0369

COLORADO POLICY RIDER

This rider amends this policy as follows:

The "Adding covered persons" section of this policy is amended so that:

Such persons, with the exception of a child born to you, will be covered without charge *from the date each joins your household* to the premium due date that falls at least 60 days later. …

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-R-CHS-CO-95	Major Medical PPO Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan

HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan
HC-R-BABY-CO-97	Colorado Policy Rider

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect definitions of a dependent that are in compliance with Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to accurately describe dependent coverage required for adopted children. The violation resulted in Recommendation # 31, that the Company establish procedures to ensure that accurate descriptions of dependent coverage required for adopted children is reflected in its policy forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E8: Failure to offer the opportunity to purchase benefits for alcohol and substance abuse in the Basic and Standard Health Benefit Plans.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(9) Availability of coverage for alcoholism

(a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract on a group basis issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article shall be sold in this state unless the policyholder under such contract *or persons holding the master contract under such contract are offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, which benefits are at least equal to the following minimum requirements:* [Emphasis added.]

(b) Outpatient benefits shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished by:

(I) An accredited or licensed hospital; or
(II) Any public or private facility or portion thereof providing services especially for the treatment of alcoholics, which is licensed by the department of human services for those purposes; or
(III) Any mental health facility approved as such by the department of human services.

It appears that the Company is not in compliance with Colorado insurance law in that it indicated that no offer to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism was made for the Basic and Standard Health Benefit Plans. In addition to providing coverage for acute detox in connection with alcohol and substance abuse, carriers are required to offer coverage for alcoholism and substance abuse pursuant to Section 10-16-104(9), C.R.S., as may be amended.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that an offer to purchase benefits for alcohol and substance abuse is provided to each employer purchasing group coverage as required by Colorado insurance law.

Issue E9: Failure to reflect correct preventive services in the Basic and Standard Health Benefit Plans.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (10) Prostate cancer screening
>
> (a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years *and in men over the age of forty years who are in high-risk categories*, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. …[Emphasis added.]

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

BASIC PREFERRED PROVIDER PLAN

	BASIC INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK[1a]
9. PREVENTIVE CARE (deductible does not apply) [6]		(For all plans, only specified preventive services are covered.)	
a) Children's services	$10 copay/visit	$10 copay/visit	50%
b) Adults' services	$10 copay/visit	$10 copay/visit	50%

STANDARD PREFERRED PROVIDER PLAN

	STANDARD INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK[1a]
9. PREVENTIVE CARE (deductible does not apply) [6]		(For all plans, only specified preventive services are covered.)	
a) Children's services	$10 copay/visit	$10 copay/visit	50%
b) Adults' services	$10 copay/visit	$10 copay/visit	50%

6 See Attachment 1 for list of covered preventive services.

Attachment 1

Covered Preventive Services	
Age 40-64	Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75 Males: prostate screening as specified in state law
Age 65 and older	Females age 65 to 74: 1 screening mammogram and clinical breast exam every 12 months Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75

The Company's Basic and Standard Health Benefit Plans do not appear to reflect correct preventive services to be covered in the following ways:

1. Either annual hemocults or 2 colorectal visualizations are to be covered between the ages of 50 and 75, not between the ages of 50 and 70.

2. Colorado state law requires that prostate screening be provided for men over the age of forty years who are in high-risk categories.

The wording in the Company's Basic and Standard Health Benefit Plans is as follows:

Page 28

Covered Preventive Services

Age 50-70	Annual hemoculls or 2 colorectal visualizations between ages 50 and 70
Females	
Ages 65-74	1 screening mammogram every year 2 colorectal visualizations between ages 50 and 70
Males	
Ages 50 & Older	1 prostate-specific antigen blood test and digital rectal examination every year; not to exceed $65 payment by the Company

The plans used by the Company for conversion plans do not appear to reflect correct preventive services to be covered in the following way:

1. Colorado state law requires that prostate screening be provided for men over the age of forty years who are in high-risk categories.

The wording used in the riders for the conversion plans is as follows:

Page 2 P660.0531
P660.0543

Covered Preventive Services

Females	
Ages 65-74	1 screening mammogram every year 2 colorectal visualizations between ages 50 and 70
Males	
Ages 50 & Older	1 prostate-specific antigen blood test and digital rectal examination every year; not to exceed $65 payment by the Company

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan

HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan
HC-R-STAT-CO-01	Colorado Policy Rider
HC-R-STAT-CO-02	Colorado Policy Rider

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct preventive services to be covered as required by Colorado insurance law.

Issue E10: Failure to reflect correctly the extent of coverage for home health services and hospice care. (Item 1 cited for the most frequently sold plan was prior issue E12 in the findings of the 2000 final examination report)

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for* home health services and *hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

A. Definitions

(3) "Home health visit" is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to 4 hours by a home health aide shall be considered as one visit.

B. General Policy Provisions Pertaining to Home Health Care

(1) The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. Prior hospitalization shall not be required.

C. Benefits for Home Health Care Services

(2) The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may

provide for fewer than 60 home health visits in any calendar year.

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties.* [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.* [Emphasis added.]

(15) "Hospice levels of care:"

(c) "Inpatient hospice respite care:" The level of care received when the patient is in a licensed facility to provide the caregiver a period of relief. Inpatient respite care may be provided only on an intermittent, non-routine, short-term basis. It may be limited to periods of five days or less.

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

B. General Provisions Pertaining to Hospice Care

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical

Director to determine the appropriateness of continuing hospice care.

(5) The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

(a) Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;

(b) Intermittent and 24 hour on-call social/counseling services; and;

(c) Certified nurse aide services or nursing services delegated to
other persons pursuant to § 12-38-132, C.R.S.

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the *twelve month period following death,* and in no event shall this maximum benefit be less than $1150. [Emphasis added.]

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

The Company has indicated that no offer to purchase coverage for benefits for the costs of hospice care was made for the most frequently sold plan in Colorado in 2003 and that it chose instead to automatically include coverage for benefits for these costs in this plan. The certificate does not appear to reflect correctly and completely the extent of coverage to be provided for hospice care services in the following ways:

One The exclusion of counseling of any type for the sole purpose of adjusting to the terminally ill covered person's death does not appear to be in compliance with Colorado insurance law concerning hospice care. Bereavement support services are required to be covered for 12 months following death for the family of the deceased person, with a maximum benefit to be no less than $1,150. Additionally, there is an exclusion reflected for services supplied to family members, other than the terminally ill covered person.

The wording in the certificate is as follows:

Page 49

Hospice Care Charges	We don't pay for (e) services supplied to family members, other than the terminally ill covered person; or (f) counseling of any type which is for the sole purpose of adjusting to the terminally ill covered person's death.

Two Nothing is reflected identifying the twelve (12) benefits (except for bereavement support services) which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

Three Nothing is reflected to indicate that benefits are allowed only for individuals who have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. Additionally, after the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

Four Nothing is reflected to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

Five Nothing is reflected to indicate that a benefit of no less than $100 is to be provided per day for three (3) routine home care services and the total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

Six Nothing is reflected concerning the benefit of short-term general inpatient (acute) hospice care or continuous home care, to be paid consistent with any other sickness or illness, which may be required during a period of crisis, for pain control or symptom management nor the requirements for prior authorization of this type of hospice care service.

The Conversion Plans used by the Company do not appear to reflect correctly and completely the extent of coverage to be provided for hospice care services in the following ways:

One A limitation for bereavement support services is reflected that appears to be more limited than allowed by Colorado insurance law. A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the primary care giver and individuals with significant personal ties as well as the immediate family. Individuals other than the immediate family would also be entitled to bereavement support services.

The wording in the plan rider is as follows:

Pages 6 , 7, & 8	P660.0531	Basic Indemnity Plan
	P660.0532	Standard Indemnity Plan
	P660.0533	Basic PPO Plan
	P660.0534	Standard PPO Plan

Indemnity Plans: 15.
PPO Plans: 16.

The following replaces all references to the "Covered Charges / Hospice Care" provision:

In addition, Hospice care services will include: (2) bereavement support services for the individual's Immediate Family during the twelve month period following the covered person's death to a maximum benefit of $1,150.

Two Nothing is reflected in the plans to indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

Three The routine home care hospice benefits do not appear to correctly reflect what is required by Colorado insurance law in the following ways:

(a) Intermittent *and* 24 hour on-call professional nursing services provided by or under the supervision of a registered nurse is to be provided; not intermittent *or* 24 hour on call professional nurse services.
(b) Intermittent *and* 24 hour on-call social/counseling services are to be provided, not intermittent *or* 24 hour on call social/counseling services.
(c) Part-time or intermittent Home Health Aide services under the supervision of a registered nurse or specialized rehabilitative therapist is reflected in the plans instead of certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.

The wording in the plan rider is as follows:

Page 7	P660.0531	Basic Indemnity
	P660.0532	Standard Indemnity
Page 8	P660.0533	Basic PPO
	P660.0534	Standard PPO

Indemnity Plans: 15.
PPO Plans: 16.

The following replaces all references to the "Covered Charges / Hospice Care" provision:

Covered Hospice care services consist of: (1) intermittent *or* 24 hour on-call professional nursing care by or under the supervision of a registered nurse; (2) intermittent *or* 24 hour on-call social / counseling services; (3) *part-time or intermittent Home Health Aide services under the supervision of a registered nurse or specialized rehabilitative therapist;* [Emphases added.]

The Company's Conversion Plans do not appear to reflect correct or complete descriptions of the benefits to be included for Home Health Care in the following way:

> The wording in the description of covered charges for home health care services indicates prior hospitalization is required for prescription drugs and medicines and laboratory services by or for a hospital to be covered. Colorado insurance law does not require prior hospitalization, just that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization.

The wording in the plans is as follows:

Page P670.0323 Basic PPO and Indemnity Health Benefit Plans

Page P670.0328 Standard PPO and Indemnity Health Benefit Plans

Covered Charges

Charges for home health care provided under the terms of a home health care plan and made by a home health care agency for: …(d) drugs and medicines which require a physician's prescription and other supplies prescribed by the attending physician, *if the cost of these items would have been covered charges had the covered person remained hospital confined*; and (e) laboratory services by or for a hospital, *if the cost of these items would have been covered charges had the covered person remained hospital confined*. [Emphases added.]

Form Name	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-R-CHS-CO-95	Major Medical PPO Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan
HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan
HC-R-STAT-CO-01	Colorado Policy Rider

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable policy forms to reflect correctly and completely the extent of coverage to be provided for home health services and hospice care as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to reflect correct covered charges for hospice care. The violation resulted in Recommendation # 19, that the Company establish procedures to ensure that required benefits for hospice care were reflected in its certificate forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E11: Failure to reflect correct coverages for maternity benefits and complications of pregnancy.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(2) Complications of pregnancy and childbirth

(a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and any individual or group service or indemnity contract issued by an entity subject to part 3 of this article *shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract.* … [Emphasis added.]

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

III. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

BASIC PREFERRED PROVIDER PLAN

	BASIC INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
10. MATERNITY a) Prenatal b) Delivery & inpatient well baby care [7]	50% (deductible does not apply) 50%	70% (deductible does not apply) 70%	50% (deductible does not apply) 50%

STANDARD PREFERRED PROVIDER PLAN

	STANDARD INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
10. MATERNITY a) Prenatal b) Delivery & inpatient well baby care [7]	70% (deductible does not apply) 70%	80% (deductible does not apply) 80%	50% (deductible does not apply) 50%

The Company's Basic and Standard Health Benefit Plans do not appear to reflect correct coverage that is to be provided for maternity, complications of pregnancy and postnatal care in the following ways:

1. The coinsurance percentage to be paid for in-network maternity coverage is 70% for the Basic PPO Plan and 80% for the Standard PPO Plan. The coinsurance percentage to be paid for the Standard Indemnity Plan is 70%.

2. Coverage for complications of pregnancy are to be paid as any other similar sickness or disease is otherwise covered under the plans, which is 70% and 80% respectively for the in-network Basic and Standard PPO Plans.

3. The plans reflect that no hospital deductible will be applied for a mother and newborn if discharged within 48 hours following a normal delivery, or 96 hours following a cesarean section. This appears to be more liberal than allowed by Colorado insurance law as the deductible is to be applied to the delivery and inpatient well baby care part of the maternity benefit regardless of the length of time spent in the hospital.

The wording in the plans is as follows:

Pages 31 and 32

PART IV – DESCRIPTION OF BENEFITS
Section B – Comprehensive Medical

Obstetrical Care and Family Planning

(1) Benefits for prenatal care are payable at 50% of covered charges and this Plan's deductible does not apply to prenatal care: and

(2) Benefits for delivery shall be payable at 50% of covered charges for both Normal Pregnancy and Complications of Pregnancy. Postnatal care and counseling shall also be payable at 50% of covered charges; and

(3) Benefits for Hospital care shall be payable at 50% of covered charges for a minimum of:

(a) 48 hours of inpatient care for a mother and her newborn child following a normal vaginal delivery; or
(b) 96 hours of inpatient care for a mother and her newborn child following a cesarean section.

This Plan's Hospital deductible will not apply for a mother and her newborn child if discharged within 48 hours following a normal delivery, or 96 hours following a cesarean section.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to reflect correct information, as required by Colorado insurance law, concerning the coverages for maternity benefits and complications of pregnancy.

Issue E12: Failure to reflect correct coverage provisions for skilled nursing facility care. (Item 3 cited for the Conversion Plans was prior issue E13 in the findings of the 2000 final examination report)

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

		BASIC PREFERRED PROVIDER PLAN	
	BASIC INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
27. SKILLED NURSING FACILITY CARE [23]	50% [Not to exceed 100 days/year]	70%. [Not to exceed 100 days/year]	50%[Not to exceed 100 days/year]

STANDARD PREFERRED PROVIDER PLAN

	STANDARD INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
27. SKILLED NURSING FACILITY CARE [23]	70% [Not to exceed 100 days/year]	80%. [Not to exceed 100 days/year]	50%[Not to exceed 100 days/year]

23 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

The Company's Basic and Standard Health Benefit Plans reflect that skilled nursing facility care for room, board and other services required for treatment must follow hospital confinement or a prior skilled nursing facility confinement. This appears to be an incorrect limitation as there is no requirement in Colorado insurance law that skilled nursing facility care for an injury or sickness must follow a hospital confinement or a prior skilled nursing facility confinement.

In the description of benefits for skilled nursing facility confinement there is no mention of the maximum number of days per year to be allowed for confinement. This would appear to allow a more liberal skilled nursing facility care benefit than is allowed by Colorado insurance law for these plans.

The wording in the plans is as follows:

Page 31

PART IV – DESCRIPTION OF BENEFITS

Section B – Comprehensive Medical

Skilled Nursing Facility Confinement

Comprehensive Medical covered charges will include charges by a Skilled Nursing Facility for room, board and other services required for treatment, provided:

(1) confinement is certified by a Physician as necessary for recovery from a sickness or injury; and

(2) the Skilled Nursing Facility confinement follows Hospital confinement or a prior Skilled Nursing Facility confinement for which benefits were payable under this section; and

(3) the Skilled Nursing Facility confinement results

from the sickness or injury that was the cause of the Hospital confinement.

Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification. In addition, covered charges will not include any charges after the date We determine that maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

The Conversion Plans used by the Company appear to reflect incorrect coverage provisions for Skilled Nursing Facility Care in the following ways:

1. There is no requirement in Colorado insurance law that skilled nursing facility care for an injury or sickness must follow a hospital confinement or a prior skilled nursing facility confinement.

2. There is no mention of the maximum number of days per year to be allowed for confinement. This would allow a more liberal skilled nursing facility care benefit than is allowed by Colorado insurance law for these plans.

3. The plans indicate covered expenses will not be more than 50% of the hospital room charge if in a semi-private room or the hospital room maximum, if in a private room. As there is no requirement in Colorado insurance law that there must be a prior hospital confinement, this would not be applicable. Additionally, the coinsurance percentages for each of the four (4) types of conversion plans are to be applied to all covered charges and not based on a limited percentage of hospital room charges.

The wording in the plans is as follows:

Page P670.0324 Basic PPO and Indemnity Plans

Page P670.0329 Standard PPO and Indemnity Plans

SCHEDULE OF INSURANCE

Covered Charges

Charges for convalescent care in a skilled nursing facility for room, board and other services required for treatment, provided the confinement: (a) is certified by a physician as necessary for recovery from a sickness or injury; (b) *follows hospital confinement or a prior skilled nursing facility confinement* [Emphasis added], (c) results from the sickness or injury that was the cause of hospital confinement.

But, skilled nursing facility covered charges for each day will not be more than 50% of: (1) the actual room charge, if the hospital confinement was in a semi-private room; or (2) the hospital room maximum, if the hospital confinement was in a private room; or the hospital in which the covered person was confined before the skilled nursing facility confinement.

Skilled nursing facility covered charges will not include any charges after the date: (i) the attending physician stops treatment or withdraws certification; and (ii) that we determine that maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

The wording in a Rider attached to each plan is as follows:

Page P660.0533	Basic PPO Plan
Page P660.0534	Standard PPO Plan
Page P660.0531	Basic Indemnity Plan
Page P660.0532	Standard Indemnity Plan

COLORADO POLICY RIDER

This rider amends this policy as follows:

14. (Indemnity Plans)
15. (PPO Plans)

The following replaces all references to the "Covered Charges / Skilled Nursing Facility" provision:

- Charges for convalescent care in a Skilled Nursing Facility for room, board and other services required for treatment, provided the confinement: (a) is certified by a physician as necessary for recovery from a sickness or injury; (b) follows Hospital confinement or a prior Skilled Nursing Facility confinement for which benefits were paid under this policy or the previous policy; and (c) results from the sickness or injury that was the cause of Hospital confinement.

  But, Skilled Nursing Facility covered charges for each day will not be more than 50% of:

(1) the actual room charge, if the hospital confinement was in a semi-private room; or

(2) the Hospital room maximum, if the Hospital confinement was in a private room, of the Hospital in which the covered person was confined before the Skilled Nursing Facility confinement.

Skilled Nursing facility covered charges will not include any charges after the date: (i) the attending Physician stops treatment or withdraws certification; and (ii) that We determine that maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan
HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan
HC-R-STAT-CO-01	Colorado Policy Rider

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect correct coverage provisions for skilled nursing facility care as mandated by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to reflect correct covered charges for skilled nursing facility care. The violation resulted in Recommendation # 20, that the Company establish procedures to ensure that the correct covered charges for skilled nursing facility care were reflected in its certificate forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E13: Failure to reflect the coverage to be provided for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1)(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders, hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuyria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

(C) As used in this subparagraph (III), "medical foods," means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

(D) Coverage of medical foods, as provided under this

subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

III. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

The Company's Basic and Standard Health Benefit Plans do not appear to reflect the mandatory coverage for inherited enzymatic disorders and in addition appear to exclude payment of benefits for "medical foods" which is one of the treatments for such conditions.

The wording in the plans is as follows:

Page 34

Limitations Covered charges will not include and no benefits will be paid for:

(4) Dental services or materials, except as described under Covered Charges; eye examination for the correction of vision or the fitting of glasses, vision materials (frames or lenses); hearing aids; drugs or medicines that do not require a Physician's prescription; vitamins, minerals, nutritional supplements or *special diets (whether they require a Physician's prescription or not*); comfort or convenience services and supplies; or [Emphasis added.]

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to reflect the coverage to be provided for inherited enzymatic disorders as required by Colorado insurance law.

Issue E14: Failure to reflect all or reflect completely some required small group provisions.

Section 10-16-214, C.R.S., Group sickness and accident insurance, states:

(1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following bases:

(c) On and after July 1, 1994, under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class of individuals that could be insured under such group life insurance policy; except that notwithstanding the provisions of section 10-7-201(1)(b), on and after July 1, 1994, such a policy shall cover at least two or more individuals at date of issue, and on and after January 1, 1996, such a policy shall cover a business group of one at the date of issue.

(3)(a) Except as provided for in subsection (2) of this section, all policies of group sickness and accident insurance providing coverage to persons residing in the state shall contain in substance the following provisions or provisions which, in the opinion of the commissioner, are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(I) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder has given the insurer written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the coverage was in force during such grace period.

(II) A provision that the validity of the policy shall not be contested, *except for nonpayment of premiums*, after it has been in force for two years from its date of issue and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during such person's lifetime unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person; [Emphasis added.]

(III) *A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued* and that all statements made by the policyholder or by the persons covered shall be deemed representations and not warranties; [Emphasis added.]

(IV) A provision that no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer; but any such amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder;

(VII) *A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate*, which may be in summary form, setting forth the essential features of the insurance coverage, including any applicable conversion or continuation privilege, and to whom the benefits are payable. If family members or dependents are included in the coverage, only one certificate need be issued for each family unit. [Emphasis added.]

(X) *A provision that, in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require,* …Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. [Emphasis added.]

(XIII) A provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy *and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law*; [Emphasis added.]

The Company's Basic and Standard Health Benefit Plans do not appear to be in compliance with Colorado insurance law in the requirement for all group sickness and accident insurance plans to contain in substance certain provisions:

1. There does not appear to be a provision relating to the entitlement of a grace period of thirty-one (31) days for payment of any premium due except the first.

2. There does not appear to be a provision reflecting that no agent has authority to change the policy or waive any of its provisions and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by an endorsement on the policy or by rider or amendment to the policy signed by the insurer; but any such amendment which reduces or eliminates coverage shall have been either requested in writing or signed by the policyholder.

3. The provision concerning the insurer's right to examine the person of the individual for whom claim is made is incomplete as the right and opportunity to make an autopsy, where not prohibited by law, is not reflected.

4. There does not appear to be a provision reflecting the notification requirements for the employee to furnish the insurer written proofs of loss for disability claims.

The wording in the plans is as follows:

Page 47

Physical Examinations	We may have the person whose loss is the basis for claim examined by a physician. We will pay for these examinations and will choose the Physician to perform them.

The Company's individual conversion plans do not appear to reflect completely all provisions required by Colorado insurance law in the following ways:

1. Failure to indicate that the time period (90 days) allowed for furnishing written proof of loss for claims is for periodic payments. Without this clarification, it is in conflict with the provision concerning notice of claim to be given within twenty (20) days for other covered charges.

2. Failure to indicate the insurer's right to have an autopsy performed in case of death where it is not forbidden by law.

The wording in the plans is as follows:

General Provisions

Page 6

Time limit on certain defenses

(a) After this policy has been in force for two years during your lifetime, *no misstatements* made in your application will be used to void this policy or to deny claim for any loss incurred after the end of those two years. [Emphasis added.]

Page 7

Time for filing proof of loss

You must give us written proof of loss for any covered charge *within 90 days after such covered charge is made.* If you fail to give us proof within this time, we will not reduce or deny claim if it was not reasonably possible for you to do so … [Emphasis added.]

Physical examination

We have the right and opportunity, at our expense, to medically examine the covered person for whom claim is made when and as often as we may reasonably require during the time a claim is pending.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-R-CHS-CO-95	Major Medical PPO Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan
HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-202 and 10-16-214, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect all required small group and individual provisions as required by Colorado insurance law.

Issue E15: Failure to reflect a complying provision regarding network adequacy.

Section 10-16-704, C.R.S., Network adequacy, states:

(1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay.

(2)(a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

The Company's Basic and Standard PPO Health Benefit Plans do not appear to reflect the provisions pertaining to network adequacy that are required by law in the event of termination of the preferred provider organization contract by the carrier or the PPO. The wording indicates that in the event of termination of the contract with the PPO, that the level of benefits paid will be those described for medical care received from "Other Than Preferred Providers". A plan sold as a preferred provider organization cannot change from paying the benefits associated with PPO providers to paying those of non preferred providers as a result of termination of a contract between the carrier and a preferred provider organization. The Company could change the PPO organization it is contracted with, but cannot terminate the PPO portion of the policy as a result of the termination of an arrangement with a Preferred Provider Organization.

The wording in the PPO plans is as follows:

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PART X – DEFINITIONS

Preferred Provider	The Company has the right to terminate the Preferred Provider Organization (PPO) portion of this policy if the Company or the Preferred Provider Organization (PPO) terminates the arrangement. In the event of termination, the Company will pay the level of benefits as described in this policy for medical care received from "Other Than Preferred Providers". In addition, the Company will assume responsibility for assisting the insured person with the Hospital Preadmission Authorization and Pretreatment Review requirements described in PART IV, Section B (1C) of this policy under the heading "Cost Containment Requirements".

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect required provisions for maintaining network adequacy to ensure compliance with Colorado insurance law.

Issue E16: Failure to reflect correct coverage for physical, occupational and speech therapy in the Basic and Standard Health Benefit Plans.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

		BASIC PREFERRED PROVIDER PLAN	
	BASIC INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	50%	70%.	50%

		STANDARD PREFERRED PROVIDER PLAN	
	STANDARD INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	70%	80%.	50%

20 Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 5 years of age.

The Company's Basic and Standard Health Benefit Plans do not appear to reflect that physical, occupational and speech therapy will be covered for medically necessary therapeutic treatment. Physical therapy does appear to be covered under the description of benefits with the services of a licensed physiotherapist, but provides a more liberal benefit than allowed in these plans as nothing is reflected concerning that no benefits will be paid for maintenance therapy after maximum medical improvement is achieved.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect correct coverage for physical, occupational and speech therapy, as required by Colorado insurance law.

Issue E17: Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member or a business or professional associate of the member or their family.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (7) Reimbursement of providers
>
> (a) Sickness and accident insurance.
>
> (I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's Basic and Standard Health Benefit Plans, the most frequently sold plan in Colorado in 2003 and its Conversion Plans reflect an exclusion that does not appear to be in compliance with Colorado insurance law. A plan could contain an exclusion for charges that would not be billed if the member did not have insurance, but the plan may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services nor can a plan deny reimbursement for covered benefits based upon the provider's status, e.g., a family member or a business or professional associate of the member or their family.

The wording in the Basic and Standard Plans is as follows:

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> **Limitations** Covered charges will not include and no benefits will be paid for:
>
> (3) the services of any person who is in the Member's or the Member's Dependent's Immediate Family;

The wording in the most frequently sold plan is as follows:

Page 60

> **Exclusions**
>
> We don't pay for services or supplies furnished by close relatives. By "close relatives", we mean: (a) your spouse, children, parents,

brothers and sisters; and (b) any person who is part of your household. And we don't pay for services or supplies furnished by business or professional associates of you or your family.

The wording in the Conversion Plans is as follows:

Page P670.0325 Basic PPO and Indemnity Plans

Page P670.0330 Standard PPO and Indemnity Plans

Excluded Charges

The following charges are not covered, nor may they be applied toward the applicable deductible amount:

- Charges for the service of any person in your immediate family, or any person in your dependent's immediate family.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-CHS-CO-95	Major Medical PPO Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan
HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that benefits may not be denied solely based on a provider's status (e.g. a family member or a business or professional associate of the member or their family), as required by Colorado insurance law.

Issue E18: Failure to reflect correct provisions for conversion and continuation privileges.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(1) Group sickness and accident insurance – conversion privileges.

(c)(I)(F) The insurer shall not be required to issue a converted policy covering any person if such person is *covered* by medicare. [Emphasis added]
…

(VIII) The converted policy may provide for the termination of coverage thereunder of any person when such person is *covered* by medicare, Title XVIII of the federal "Social Security Act" as added by the "Social Security Amendments of 1965" or as later amended or superseded. [Emphasis added.]

(d) (XIX) The employer shall not be required to offer continuation of coverage of any person if such person is *covered* by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act". [Emphasis added.]

(f) A group sickness and accident insurance policy that provides for continued coverage after an employee is terminated, as required by paragraph (b) of this subsection (1), *shall also include a provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage, to obtain* from the insurer underwriting the group policy, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, *an individual policy* of sickness and accident insurance which shall conform to the descriptions, limitations, and requirements of converted policies pursuant to subparagraph (I) of paragraph (c) of this subsection (1). [Emphases added.]

(3) Continuation of policies and group service contracts - reduction in hours of work. Every group policy or group service contract delivered or issued for delivery in this state by an insurer subject to the provisions of part 2 of this article or by an entity subject to the provisions of part 3 or 4 of this article that covers full-time employees working forty or more hours per week shall contain a provision that the policyholder may elect to contract with the insurer or other entity to continue such policy or contract under the same conditions and for the same premium for such employees and their dependents even if the policyholder or employer *reduces the working hours* of such employees to less than thirty hours per week, if the following conditions are met: [Emphasis added.]

(a) The covered employee has been continuously employed as a full-time employee of the policyholder or employer and has been insured under the group policy or group service contract, or under any group policy or group service contract providing similar benefits which said group policy or group service contract replaces, for at least six months immediately prior to such reduction in working hours;

(b) The policyholder has imposed such reduction in working hours due to economic conditions; and

(c) The policyholder intends to restore the employee to a full forty-hour work schedule as soon as economic conditions improve.

The Company's Basic and Standard Health Benefit plans do not appear to reflect complete or correct continuation privileges required by Colorado insurance law in the following ways:

- Reflecting that the Company is not required to offer continuation coverage to a person who qualifies for Medicare or Medicaid. Colorado insurance law states that insureds may be refused only if they are covered by Medicare or Medicaid.

- There is no provision relating to continuation privileges when there is a reduction in hours of work.

The wording in the Basic and Standard Plans is as follows:

Page 19

PART III – HOW TO BE INSURED

SECTION C – CONTINUATION OF COVERAGE

(1) Qualification for Continuation

(c) the person seeking continuation does not qualify for Medicare or Medicaid:

The Company's most frequently sold plan in Colorado in 2003 does not appear to reflect complete or correct continuation or conversion privileges required by Colorado law in the following ways:

Continuation

- Stating that the Company is not required to offer continuation coverage to a person who is *eligible* for Medicare or Medicaid. Colorado insurance law states that insureds may be refused only if they are *covered* by Medicare or Medicaid.

- The plan does not reflect the provision allowing a covered employee or surviving spouse or dependent, at the expiration of such continued coverage and without interruption, to obtain an individual policy.

- There is no provision relating to continuation privileges when there is a reduction in hours of work.

Conversion

- Indicating that a covered person can't convert their coverage if *eligible* for Medicare by reason of age. Colorado insurance law states an insurer is not required to offer a converted policy to a person if *covered* by Medicare.

The Company's Conversion Plans reflect a reason for non-renewal of conversion coverage that does not appear to be in compliance with Colorado insurance law. A converted plan may be terminated when such person is *covered* by Medicare, which does not equate to, if they are *eligible* for Medicare by reason of age.

The wording in the plans is as follows:

Page 1

This Policy is renewable for adults until Medicare age. Premiums can be changed.

The Company's application used for Conversion Coverage has an age limitation for an applicant that does not appear to be in compliance with Colorado insurance law. An insurer is not required to offer a converted policy to a person if *covered* by Medicare, which does not equate to, if they are *eligible* for Medicare by reason of age.

The wording in the application is as follows:

TO BE COMPLETED BY THE GROUP POLICYHOLDER (For Persons Under Age 65 only)

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-CHS-CO-95	Major Medical PPO Plan
HC-P-85	Preferred Provider Organization Basic Health Benefit Plan
HC-P-85	Preferred Provider Organization Standard Health Benefit Plan
HC-P-85	Indemnity Basic Health Benefit Plan
HC-P-85	Indemnity Standard Health Benefit Plan
HC-A-85 (3/00)	Application for Group Converted Major Medical Policy

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect accurate information concerning conversion and continuation privileges as required by Colorado insurance law.

Issue E19: Failure to prominently display the required small group disclosure statement on small employer applications. (This was prior issue E1 in the findings of the 2000 final examination report)

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. RULES

E.1. The following disclosure statement, prominently displayed in bold type capital letters no smaller than 14 point for printed materials or in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except the Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Regulation 4-2-20), *small employer application forms*, and small employer renewal notices, and on all written refusals to insure which are related to health coverage for a business group of one. [Emphasis added]

"Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2-50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during open enrollment periods as specified by law."

One of the Company's small employer applications (GG-012638CO) does not reflect the required small group disclosure statement required on all small employer applications and another application (GG-010702CO) reflects the disclosure statement, but it is not displayed in a clear and conspicuous manner.

Form Name	Form Number
SPECIFICATIONS FOR A PLAN OF GROUP INSURANCE	GG-012638CO
SPECIFICATIONS FOR A PLAN OF GROUP INSURANCE (FOR LESS THAN 10 LIVES)	GG-010702CO 11/01

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its applications to prominently display the required small group disclosure statement as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to display or display in correct format the required fourteen (14) point disclosure statement on applications. The violation resulted in Recommendation # 8, that the Company establish procedures to ensure that the required disclosure statement be displayed in the proper format on all small employer application forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E20: Failure to reflect correct group coordination of benefit provisions.

Repealed and Repromulgated Regulation 4-6-2, GROUP COORDINATION OF BENEFITS, states:

Section 2. Purpose

The purpose of this regulation is to:

F. Require that COB provisions be consistent with this regulation.

Section 3. Applicability and Scope

This regulation shall apply to all group health coverage plans issued by carriers licensed to do business in Colorado under Article 14, 16 and 19 of Title 10, C.R.S.

Section 4 Definitions

As used in this regulation, these words and terms have the following meanings:

H. "Plan" means a form of coverage with which coordination is allowed or required. The definition of plan in the group contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. …

(1) The definition shown in the model COB provision in Appendix A is an example but any definition that satisfies this subsection may be used.

(3) Plan may include:

(a) Group insurance contracts and group subscriber contracts;

(b) Uninsured arrangements of group or group-type coverage;

(c) Group or group-type coverage through closed panel plans;

(d) Group-type contracts. Group-type contracts are contracts, which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular

organization or group, including blanket coverage;

(e) The amount by which group or group-type hospital indemnity
benefits exceed $200 per day;

(f) The medical care components of group long-term contracts, such as skilled nursing care;

(g) The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

(4) Plan shall not include

(e) Group or group-type hospital indemnity benefits of $200 per day or less;

Section 6. Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

D. Order-of-Benefit Determination

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a

dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(d) If the parents are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial parent; and then

(iv) The plan of the spouse of the noncustodial parent.

The Company's Basic and Standard Health Benefit Plans do not appear to use the correct hospital indemnity benefit amount in determining the form of coverage with which coordination of benefits is allowed or required. Colorado insurance law indicates this amount is not to exceed $200 per day and the Company's plans reflect that it will not exceed $100 per day.

The Coordination of Benefits provisions in the Company's most frequently sold plan do not appear to be consistent with what is required by Colorado insurance law in the following ways:

1. The definition of the types of coverage that will be considered in applying the COB provisions of the contract do not appear to include:
    - Uninsured arrangements of group or group-type coverage
    - group or group-type coverage through closed panel plans
    - the medical care components of group long-term care contracts, such as skilled nursing care
    - the medical benefits coverage in group, group-type and individual automobile traditional "fault" type contracts,

2. The definition of the types of coverage that will not be considered in applying the COB provisions of the contract do not appear to reflect:
    - Individual or family insurance contracts
    - individual or family subscriber contracts
    - individual or family coverage through closed panel plans
    - individual or family coverage under other prepayment, group practice and individual practice plans
    - benefits provided in group long-term care insurance policies for non-medical services
    - Medicare supplement policies.

3. The following does not appear to be reflected:

    - The one exception to plans not containing a consistent coordination of benefits provision always being considered primary does not appear to be reflected.

4. The provision reflected concerning order-of-benefit determination for Non-Dependent or Dependent does not appear to be correct as there is no distinction as to which plan is primary for persons who are Medicare beneficiaries. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

5. There does not appear to be a provision concerning order-of-benefit determinations indicating that if both parents have the same birthday, the plan that has covered either of the parents longer is primary.

6. The benefit determination among the plans of the parents and the parents' spouses (if any) when there is no court decree allocating responsibility for the child's health care services or expenses, does not appear to be correct. The third and fourth order of benefit determinations appear to be reversed.

7. An incorrect hospital indemnity benefit amount that is used in determining the form of coverage with which coordination of benefits is allowed or required appears to be reflected. This amount is not to exceed $200 per day and the Company's plan reflects that it will not exceed $100 per day.

The wording in the Company's Basic and Standard plans is as follows:

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PART V – COORDINATION WITH OTHER BENEFITS

Definitions

except that the term Plan will not include benefits provided under a student accident policy ,nor will the term Plan include benefits provided under a state medical assistant program where eligibility is based on financial need. Also, the term Plan will not include group-type hospital indemnity benefit of $100 per day or less; but will include the amount by which group or group-type hospital indemnity benefits exceed $100 per day.

The wording in the Company's most frequently sold plan is as follows:

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COORDINATION OF BENEFITS

Definitions

"Plan" means any of the following that provides health expense benefits or services:

(A) group, blanket, or franchise insurance plans;

(B) group Blue Cross plans, group Blue Shield plans, group or group-type coverage through HMOs, or other service or prepayment plans on a group basis;

(C) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

(D) group or group-type hospital indemnity benefits which exceed $100.00 per day;

(E) programs or coverages required or provided by law, including Medicare or other governmental benefits;

(F) medical benefits provided by group, group-type and individual automobile "no-fault" type contracts.

"Plan" does not include school accident-type coverages; a state plan under Medicaid; any plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan; or group or group-type hospital indemnity benefits of $100.00 per day or less. Nor does it include any plan we say we supplement. Plans that we supplement are named in the schedule.

Coordination of Benefits (Cont.)

How This Provision Works

(B) A plan that covers a person as an active employee or as a dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second.

But, if the plan that we're coordinating with does not have a similar provision for such persons, then (B) will not apply.

(D) For a dependent child of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member:

- When a court order makes one parent financially responsible for the health care expenses of the dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody;
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan
CGP-3-R-CHS-CO-95	Major Medical PPO Plan

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Repealed and Repromulgated Regulation 4-6-2. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect correct group coordination of benefit provisions as required by Colorado insurance law.

Issue E21: Failure to correctly define the requirements to qualify as an eligible employee. (This was prior issue E18 in the findings of the 2000 final examination report)

Section 10-16-102, C.R.S., Definitions, states:

> (15) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (7.5)(a) Effective January 1, 1995, if a small employer carrier offers coverage to a small employer, such small employer carrier shall offer the same coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer coverage to only certain eligible individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in section 10-16-118(1)(c).

Amended Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states:

> Section 5. Issuance of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> (2) The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, a carrier must offer coverage to all small employers for all employees with a regular work week of at least 24 hours on a permanent basis. …

Some of the Company forms (identified below) used in Colorado in 2003 appear to incorrectly limit the requirements to qualify as an eligible employee in the following way:

1. An employee does not have to be actively at work to be an eligible employee.

The wording in the forms, identified by form number as specific for Colorado, is as follows:

SPECIFICATIONS FOR A PLAN OF
GROUP INSURANCE
(FOR LESS THAN 10 LIVES)
Form No. GG-010702CO

Page 2

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees shall be eligible. Full-time employee means one who regularly works at the number of hours in the normal work week established by this planholder (but not less than 30 hours per week) at his planholder's place of business.

SPECIFICATIONS FOR A PLAN
OF GROUP INSURANCE
Form No. GG-012638CO

Page 2

Conditions of Agreement

It is understood that no individual shall become insured while not actively at work** on a full-time basis, and only full-time employees shall be eligible. Full-time employee means one who regularly works the number of hours in the normal work week established by this planholder (but not less than 30 hours per week or as provided by state law) at the planholder's normal place of business. It is further understood that no agent has power on behalf of The Guardian Life Insurance Co. of America to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving or receiving any information. (** Based on statutory requirements, this "actively at work" requirement will be waived for major medical insurance. Check with Guardian for details.)

CERTIFICATE OF COVERAGE
Most frequently sold plan to small employers in Colorado in 2003
CGP-3-R-CHS-CO-95

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ELIGIBILITY FOR MAJOR MEDICAL COVERAGE

Employee Coverage

Eligible Employees *full-time employee. …*	To be eligible for *employee* coverage you must be an active
When Your Coverage Starts	*Employee* benefits are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on a *full-time* basis on the scheduled effective date unless you are disabled. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, unless you are disabled, we will postpone your coverage until the date you return to active *full-time* work. Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-105, C.R.S. and Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect a correct definition of employee eligibility requirements as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to correctly define the requirements to qualify as an eligible employee. The violation resulted in Recommendation # 25, that the Company establish procedures to ensure that employee eligibility requirements were correctly defined in its policy forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E22: Failure to provide coverage for spinal manipulation in the Basic and Standard Health Benefit Plans.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2003

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

Benefit Grid

2003 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER
2003 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER

PART B: SUMMARY OF BENEFITS

		BASIC PREFERRED PROVIDER PLAN	
	BASIC INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)			
1. TMJ with a medical basis	50%	70%	50%
2. Spinal manipulation	50%	70%	50%

		STANDARD PREFERRED PROVIDER PLAN	
	STANDARD INDEMNITY PLAN	IN-NETWORK	OUT-OF-NETWORK [1a]
31. SIGNIFICANT ADDITIONAL SERVICES (List up to 5)	70%	80%	50%
1. TMJ with a medical basis	70%	80%	50%
2. Spinal manipulation			

The Company's Basic and Standard Health Benefit Plans do not appear to cover one of the Significant Additional Services required to be covered. Spinal manipulation is not reflected in the covered charges and the Company has responded to the examiner's question concerning this that the Basic and Standard Plans do not provide coverage for spinal manipulation.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised the Basic and Standard Health Benefit Plan certificates to reflect that spinal manipulation is covered as required by Colorado insurance law.

Issue E23: Failure to reflect the correct number of days to be allowed for a break in coverage.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety days* prior to the effective date of the new coverage. [Emphasis added.]

Amended Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

III. Applicability and Scope

This amended regulation shall apply to all health coverage plans which are issued or renewed on or after November 1, 1999.

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

B. Exception: Minimum ninety (90) day gap for creditable coverage

Colorado law requires health coverage plans to waive any exclusionary time periods applicable to a pre-existing condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than *ninety (90) days* prior to the effective date of the new coverage. [Emphasis added.] Colorado law prevails over the federal regulations.

The Refusal of Group Insurance Form used by the Company in 2003, reflects an incorrect number of sixty-three (63) instead of ninety (90) days to be allowed for a break in coverage under Colorado insurance law. Colorado law prevails over the federal regulations and indicates creditable coverage may be credited and certified if such creditable coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage.

The wording in the form is as follows:

> This group health benefit plan contains a preexisting condition exclusion that is limited to a maximum of 6 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period prior to an individual's enrollment date. The exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede *a break in coverage of 63 days or more*. [Emphasis added.] To determine if any preexisting condition limitation will apply to you, you must present your certificates of prior creditable coverage.

Form Number	Form Name
GG-982CO	Refusal of Group Insurance

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118, C.R.S. and Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised the Refusal of Group Insurance Form to reflect the correct number of days to be allowed for a break in coverage as required by Colorado insurance law.

Issue E24: Failure to reflect the correct maximum combined period of exclusion of coverage and preexisting conditions for late enrollees.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

> (1) A health coverage plan that covers residents of this state:
>
> (c) Shall exclude coverage for late enrollees for the greater of twelve months or for no more than an eighteen-month-preexisting condition exclusion; except that, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, *the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan*. … [Emphasis added.]

The Company's Basic and Standard Health Benefit Plans appear to reflect a combined period of exclusion of coverage and preexisting condition limitations that is more restrictive than allowed by Colorado insurance law. A maximum of only eighteen (18) months is allowed for late enrollees but the wording in the plan indicates a twelve (12) month period of exclusion of coverage and a preexisting condition restriction period of twelve (12) months for an employer group of one.

The wording in the plans is as follows:

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PART III – HOW TO BE INSURED

Effective Date for Contributory Insurance

If request for contributory insurance is made by a Late Entrant as defined below, Insurance will be in force on the date 12 months after the date of request, provided, on such date:

a. you are an Eligible Employee; and

b. for Dependent insurance, the Dependents continue to meet this plan's definition of Dependent.

For any Late Entrant, when his or her insurance becomes effective, this plan's preexisting condition restriction will be applicable: a) for 6 months for an employer group of 2-50; or b) for 12 months for an employer group of one.

Form Number	Form Name
CGP-3-CO-BP-et al	Basic Preferred Provider Organization Health Benefit Plan
CGP-3-CO-SP-et al	Standard Preferred Provider Organization Health Benefit Plan
CGP-3-CO-BI-et al	Basic Indemnity Health Benefit Plan
CGP-3-CO-SI-et al	Standard Indemnity Health Benefit Plan

Recommendation No. 24:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certificates to reflect the correct maximum combined period of exclusion of coverage and preexisting conditions for late enrollees as required by Colorado insurance law.

Issue E25: Failure to display a fraud warning that is substantially the same as required by law.
(This was prior issue E15 in the findings of the 2000 final examination report)

Section 10-1-128, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states:

(6)(a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:

> **"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."**

The Company's application for conversion coverage displays a "fraud warning" that does not appear to meet the requirement of being substantially the same as the one required to be displayed by Colorado insurance law.

The wording displayed in the application is as follows:

> Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insured, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Form Number	Form Name
HC-A-85 (3/00)	Application for Group Converted Major Medical Policy

Recommendation No. 25:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-1-128, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its applications to reflect a fraud warning that is substantially the same as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to display a fraud warning that was substantially the same as required by law. The violation resulted in Recommendation # 22, that the Company establish procedures to ensure that the "Fraud Warning" was reflected in substantially the same wording as required by Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E26: Failure to reflect correct information in a conversion plan application concerning issuance of conversion coverage.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(1) Group sickness and accident insurance – conversion privileges.

(a) If the group insurance policy provides hospital, surgical, or major medical insurance or any combination of these coverages on an expense-incurred basis, for other than specified diseases or accidental injuries only, the health benefit plan shall also contain a conversion privilege conforming to the requirements of paragraph (c) of this subsection (1).

(c)(I) A group policy delivered or issued for delivery in this state which provides hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee, dependent, or member whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety or with respect to an insured class or failure of the employee or member to pay any required contribution and who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination is entitled to have issued by the insurer a policy of sickness and accident insurance, referred to in this paragraph (c) as the "converted policy", subject to the following conditions:

(A) Written application for the converted policy shall be made and the first premium paid to the insurer no later than thirty-one days after such termination.

(B) The converted policy shall be issued without evidence of insurability.

(C) The initial premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of the insurance provided. Conditions pertaining to health shall not be an acceptable basis of classification for the purposes of this paragraph (c). The frequency of premium payments shall be the frequency customarily required by the insurer for the policy form and plan selected, but the insurer shall not

require premium payments less frequently than quarterly without the consent of the insured.

(D) The effective date of the converted policy shall be the day following the termination of insurance under the group policy. [Emphasis added.]

In its application for conversion coverage, the Company appears to reserve a time period for determining if coverage will be issued that is not in compliance with Colorado insurance law. The application indicates that Guardian will advise the applicant within sixty (60) days of the date of the application as to whether it will issue the insurance applied for.

With some exceptions conversion coverage is guaranteed, without evidence of insurability, and is to be effective on the day after the prior coverage terminates. As to whether the applicant fits into one of the exceptions would be known to the Company by the answers to questions on the application.

The wording in the application is as follows:

> I hereby apply for a converted policy on the form now being used by Guardian in the state where I live. I understand that only those persons who were covered under the group policy from which conversion is to be made are eligible for coverage without evidence of good health. The converted policy, if issued, will be effective on the date coverage under the group plan ends. Guardian will advise me within 60 days of the date of this application whether it will issue the insurance applied for.

Form Number	Form Name
HC-A-85 (3/00)	Application for Group Converted Major Medical Policy

Recommendation No. 26:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its applications to reflect correct information concerning issuance of conversion coverage as required by Colorado insurance law.

Issue E27: Failure to use the exact required format or to correctly represent the benefits, conditions, or terms of coverage in Health Benefit Plan Description Forms.

Amended Regulation 4-2-20, CONCERNING THE COLORADO COMPREHENSIVE HEALTH BENEFIT PLAN DESCRIPTION FORM, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), and 10-16-108.5(11)(b). C.R.S., states:

> Section 4. RULES
>
> C. Carriers *shall use the exact format found in Appendix A* for the Colorado Health Plan Description Form, including all headings, notes, row numbers, and *footnotes*. *All boxes must be filled in.* Carriers may modify box dimensions, reduce margins, or use a landscape rather than a portrait page layout format, *but carriers shall follow the exact requirements* and use only the choices set forth in the directions found in Appendix B of this regulation. A carrier may also add its logo to the form and print the form in color or black and white. Pursuant to Section 10-3-1104(1), C.R.S., in completing the form, *carriers shall not misrepresent the benefits, advantages, conditions, or terms of the policy*. [Emphases added.]

Appendix A

Part D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?		
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?		
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?		
39. What is the main customer service number?		
40. Whom do I write/call if I have a complaint or want to file a grievance? [6]		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.		

PART E: COST

43. What is the cost of this plan?	

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

Endnotes

[3] "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[4] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g. employer) for details.

[6] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

The Company's Health Benefit Plan Description Forms for the Basic and Standard PPO and Indemnity Plans do not appear to have used the exact format found in Appendix A which requires all headings and all boxes filled in. The following sections are not reflected:

- PART D: USING THE PLAN
- PART E: COST
- PART F. PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

Additionally, the Health Benefit Plan Description Forms for the Basic and Standard PPO and Indemnity Plans do not reflect Endnotes 3, 4, 5 and 6.

The Company's Health Benefit Plan Description Forms appear to misrepresent the benefits, conditions or terms of its Basic and Standard PPO and Indemnity Plans and the most frequently sold plan in Colorado in 2003 in the following ways:

1. The Basic and Standard Certificates do not reflect that repairs and replacement needed because of normal usage of prosthetic devices are to be covered, that coverage is to be provided for the lesser of purchase or rental price for home-administered oxygen, or that the cost of prosthetic devices for arms or legs or any parts thereof are not subject to the annual DME cap. (See Comment Forms E-3 and E3-First and Second Addendum) The Health Benefit Plan Description Forms reflect these benefits and this condition of coverage in Endnote 12 (Basic Plans) and Endnote 15 (Standard Plans).

2. The Basic and Standard Certificates reflect incorrectly that there is a $10.00 copay for a well baby newborn pediatric examination and does not reflect that an in-hospital newborn hearing screening is to be covered under well baby care. (See Comment Forms E6 and E6-First Addendum) The Health Benefit Plan Description Forms do not reflect the $10.00 copay and do reflect the newborn hearing screening benefit in Endnote 5.

3. The Basic and Standard Certificates do not reflect that immunization deficient children are not bound by recommended ages nor that coverage is provided for one (1) newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery. Additionally an incorrect age grouping of 13 months through 24 months is reflected. (See Comment Form E6-Second Addendum) The Health Benefit Plan Description Forms in Attachment 1 do reflect this condition of coverage, the home visit benefit for a newborn and a correct age grouping of "Age 13-35 months".

4. The Basic and Standard Certificates do not reflect correctly the following preventive services to be covered: a) Either annual hemocults or 2 colorectal visualizations to be covered between 50 and 75 years of age in stead of between 50 and 70 years of age, b) A clinical breast exam for females age 65 to 74, c) Prostate screening for men over the age of forty years who are in high-risk categories (See Comment Form E10) The Health Benefit Plan Description Forms do reflect the clinical breast exam for females age 65 to 74 and for males, prostate screening as specified in state law. However, the Basic PPO and the Basic and Standard Indemnity Health Benefit Plan Description Forms reflect that the annual hemocults or 2 colorectal visualizations to be covered between 50 and 75 years of age are covered under the Standard Plan only.

5. The Basic and Standard Certificates do not reflect the correct coinsurance percentages for in-network maternity coverage in the Basic and Standard PPO Plans and the Standard Indemnity Plan. (See Comment Form E12) The Health Benefit Plan Description Forms do reflect the correct coinsurance percentages for in-network maternity coverage for all the Basic and Standard Plans.

6. The Basic and Standard Certificates do not reflect that there is a maximum number of days

per year to be allowed for confinement in a skilled nursing facility. (See Comment Form E13) The Health Benefit Plan Description Forms for all the Basic and Standard Plans do reflect this limitation of the days not exceeding 100 days per year.

7. The Basic and Standard Certificates do not reflect the coverages to be provided for diabetes, except to indicate that insulin is also a covered prescription medicine. (See Comment Form E15) The Health Benefit Plan Description Forms for all the Basic and Standard Plans do include Endnote 6 reflecting the coverage of expendable medical supplies for the treatment of diabetes.

8. The Basic and Standard Certificates do not reflect that there is coverage for occupational and speech therapy except as part of Home Health Care, Hospice Care or for congenital defects and birth abnormalities for dependents up to the age of five (5). Additionally, nothing is reflected concerning that no benefits will be paid for maintenance therapy after maximum medical improvement is achieved. (See Comment Form E18) The Health Benefit Plan Description Forms for all the Basic (Endnote 11) and Standard Plans (Endnote 14) do reflect in Footnote 14 that occupational and speech therapy are to be covered and that benefits will not be paid for maintenance therapy after maximum medical improvement is achieved, except as required by law for children under 5 years of age.

9. The Basic and Standard Certificates do not reflect that non-emergency care, delivered in an emergency room, is to be covered if the person was referred by their primary care physician as well as by the company. (See Comment Form E19) The Health Benefit Plan Description Forms for all the Basic and Standard Plans do include this provision in Endnote 9.

10. The Basic and Standard Certificates do not reflect coverage for the significant additional service of spinal manipulation and the Company has indicated it is not covered by these plans. (See Comment Form E28) The Health Benefit Plan Description Forms for all the Basic and Standard Plans indicate in Part B: Summary of Benefits, Item 31, that the service of spinal manipulation is covered.

11. The most frequently sold plan in Colorado in 2003 reflects incorrect wording concerning the time period to be used for determining when preexisting conditions are to be covered. (See Comment Form E31) The Health Benefit Plan Description Form for this plan indicates in Part C: Limitations and Exclusions, Item 34 that if the plan has a waiting period for enrollment, this would have to be used as the beginning date of the six month qualification period rather than the enrollment date for the coverage.

Form Number	Form Name
None	Health Benefit Plan Description Forms for: 1. Basic PPO Plan 2. Standard PPO Plan 3. Basic Indemnity Plan 4. Standard Indemnity Plan 5. Major Medical PPO Plan (most frequently sold in Colorado)

Recommendation No. 27:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-20. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Health Benefit Plan Description Forms to reflect the exact format and to correctly represent the benefits, conditions, and terms of the plans as required by Colorado insurance law.

Issue E28: Failure to include all health insurance forms in use on the 2003 annual forms report.
(This was prior issue E2 in the findings of the 2000 final examination report)

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states:

> (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted by January 15, 1993, and not later than December 31, or each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements Of Certification For Accident And Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms and Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to §§ 10-1-109, 10-4-419, 10-4-725,10-15-105 and 10-16-107.2 and 10-16-119, C.R.S., states:

> Section 4. Definitions
>
> For the purposes of this regulation:
>
> D. "Annual Report for health coverage" shall mean a list of all policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and *riders* for any sickness, accident, and/or

health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.

The Company provided a copy of the 2003 Annual Report of Forms that was filed June 18, 2003, with the Division of Insurance. This report does not appear to reflect the following forms:

HC-R-HIPAA-97	Policy Rider
HC-R-CO-DEF-94	Colorado Policy Rider
HC-R-STAT-CO-02	Colorado Policy Rider
HC-R-PREG-01-CO	Colorado Policy Rider
HC-P-PD-CO-01-BS	Colorado Policy Rider
HC-R-IED-CO-02	Colorado Policy Rider
HC-R-POB-CO-02	Colorado Policy Rider

Recommendation No. 28:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-107 and 10-16-107.2, C.R.S. and Amended Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all policy forms or other evidence of health care coverage currently in use are included on the list submitted as an Annual Report of health insurance forms as required by Colorado insurance law,

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to include all health insurance forms in use on the 2000 annual forms report. The violation resulted in Recommendation # 9, that the Company establish procedures to ensure that all policy forms or other evidence of health care coverage currently in use, are included on the list submitted as an Annual Report of health insurance forms. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E29: Certifying and using forms that in some cases do not comply with Colorado insurance law. (This was prior issue A2 in the findings of the 2000 final examination report)

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 through E38.

Recommendation No. 29:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that evidence of coverage forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company, and as required by Colorado insurance law.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for certification and use of non-compliant forms. The violation resulted in Recommendation # 2, that the Company establish procedures to ensure that evidence of coverage forms, to be issued or delivered to Colorado insureds, comply with statutory mandates as certified to by an officer of the Company. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C. R. S.

CLAIMS
FINDINGS

Issue J1: Failure in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law. (This was prior issue J1 in the findings of the 2000 final examination report).

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(1) The general assembly finds, determines, and declares that:

(a) Patients and health care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner, even in the case of claims that are submitted on standard forms and do not require additional information for processing; and

(b) Unnecessary delays in the payment of routine and uncontested claims for reimbursement represent an unwarranted drain on health care providers' resources, which could be better spent attending to the needs of patients, as well as wasting the time and money of the patients themselves. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims.

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by

the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Paid and Denied Claims Received Electronically in 2003 Exceeding 30 Days

Data provided by the Company indicated a population of 9,576 paid and denied group claims received electronically in 2003. The examiners identified 330 claims from this population as taking over thirty (30) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 330 files. Fourteen (14) of the claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
330 *	50	14	28%

*(3% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2003 Exceeding 45 Days

Data provided by the Company indicated a population of 9,424 paid and denied group claims received non-electronically in 2003. The examiners identified 148 claims from this population as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 148 files. Thirty-nine (39) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
148 *	50	39	78%

*(2% of all paid and denied non-electronic claims)

Paid and Denied Claims Received in 2003 Exceeding 90 Days

Data provided by the Company indicated 19,000 paid and denied group claims received in 2003. The examiners identified twenty-eight (28) claims from this population of 19,000 as taking over ninety (90) days from date of receipt to process. None of these twenty-eight (28) claims involved a fraud investigation. These claims do not appear to have been paid, denied or settled as required by Colorado insurance law with respect to the ninety (90) day time period.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
28	N/A	28	100%

(< 1% of all paid and denied claims)

Recommendation No. 30:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that, in compliance with Colorado insurance law, all clean electronic claims are paid, denied or settled within thirty (30) days; all clean non-electronic claims are paid, denied or settled within forty-five (45) days, and except where fraud is involved, all claims are paid, denied, or settled within ninety (90) days.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law. The violation resulted in Recommendation # 43, that the Company establish procedures to ensure that all clean electronic claims are paid, denied or settled within thirty (30) days; all clean non-electronic claims are paid, denied or settled within forty-five (45) days, and absent fraud, all claims are paid, denied, or settled within ninety (90) days. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C. R. S.

Issue J2: Failure to follow correct procedure for denial of benefits.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (4)(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier *within thirty calendar days after receipt of such request.* Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to *timely* submit additional information requested under this paragraph (b) subject to resubmittal of the claim or the appeals process. … [Emphases added]

Section 10-16-113, C.R.S., Procedure for denial of benefits, states:

> (1) A health coverage plan shall not make a determination that it will deny a request for reimbursement for or coverage of medical treatment or other benefits for a covered individual on the grounds that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.
>
> (2) Following a denial by the health coverage plan, such plan shall notify the covered person in writing. The content of such notification and the deadlines for making such notification shall be made pursuant to regulations promulgated by the commissioner.
>
> (4) All written denials shall be signed by a licensed physician familiar with standards of care in Colorado.

It was noted during the review of the Company's disagree responses to Comment Form # J1, issued for electronically received claims exceeding thirty (30) days to process, that thirty (30) calendar days were not allowed in all cases for additional information to be furnished prior to denial of the claim for lack of the requested information.

It was noted during the review of the Company's disagree responses to Comment Form # J1-Second Addendum, issued for claims exceeding ninety (90) days from date of receipt to process, that thirty (30) calendar days were not allowed for additional information to be furnished prior to denial of the claim identified below, for lack of the requested information.

It was noted during the review of the Company's Paid and Denied claims that thirty (30) calendar days were not allowed in all cases for additional information to be furnished prior to denial of the claim for lack of the requested information.

In the sample of forty-nine (49) denied claims received in 2003, the two (2) claims identified below were denied with a reason of: "We don't pay for services or supplies which are not medically necessary to diagnose or treat a sickness or injury, are not accepted by a professional medical society in the U.S. as beneficial for the control or cure of the sickness or injury being treated, or are not furnished within the framework of generally accepted methods of medical management currently used in the U.S." Neither of these two (2) claim files appear to have a written notification to the covered person that is signed by a licensed physician familiar with standards of care in Colorado.

Recommendation No. 31:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in the denial of benefits.

Issue J3: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The data being entered into the Company's claim system and used for computing the days from initial receipt of a claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedure:

- The paid date being entered in the Company's system and used to compute the processing time for claims is the date the claim adjudication is completed by the claims examiner. The Explanation of Benefit's and checks are printed and mailed the day after adjudication and if adjudicated on a Friday are printed and mailed on the following Monday.

This procedure creates an additional one or two calendar days beyond what is entered in the Company's system as processing time and results in an inability to accurately track the number of days utilized for processing of claims, to determine in all instances those for which late payment interest and penalties would apply, and to correctly calculate the amount of interest due.

Recommendation No. 32:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in accurately determining the number of days used to process claims.

Issue J4: Failure to pay and/or correctly calculate applicable late payment interest/penalty in some cases. (This was prior issue J2 in the findings of the 2000 final examination report)

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The Company's computation and payment of late payment interest/penalties is not system generated, but requires manual intervention by the claims approver and the amounts are paid concurrently with the claim.

Two claims should have had late payment interest calculated and paid when originally processed. Once noted on the Comment Form the Company issued EOB's and checks for the interest due. Additionally, as a result of the incorrect dates entered in the claims system for the "Paid Date", the amounts of interest calculated are incorrect.

One claim had an incorrect late payment interest amount calculated when originally processed. Once noted on the Comment Form the Company issued an EOB and check for the additional interest due. Additionally, as a result of the incorrect dates entered in the claims system for the "Paid Date", the amounts of interest calculated are incorrect.

One claim was adjusted as a result of receipt of a new claim on December 22, 2003, identifying the provider as a PPO. The claims approver adjusted the original claim and incorrectly changed the received date back to the original receipt date of the incorrect claim form and paid late payment interest. No late payment interest was due, resulting in an overpayment of $ .33¢.

One claim should have had late payment interest calculated and paid when originally processed. Once noted on the Comment Form the Company issued EOB's and checks for the interest due. Additionally, as a result of the incorrect dates entered in the claims system for the "Paid Date", the amount of interest calculated is incorrect.

One claim was received on February 18, 2003, additional information was requested February 26, 2003 and received April 8, 2003. Payment in the amount of $57.50 was not processed until June 9, 2003, 111 days after receipt. An incorrect late payment penalty amount of $5.95 was paid instead of the correct amount of $5.75.

One claim should have had late payment interest calculated and paid when originally processed. Once noted on the Comment Form the Company issued an EOB and check for the interest due in the amount of $ .07¢

The Company had paid late payment interest on one claim, but the amount was calculated incorrectly. Once noted on the Comment Form the Company issued an EOB and check for an additional payment of interest in the amount of $ .27¢.

The Company indicated late payment interest and a penalty were paid on one claim in the amount of $27.70. It does not appear that a penalty was due and it appears the interest amount on allowable benefits of $277.00 would have been only $2.35.

Several claims should have had late payment interest/penalty calculated and paid when originally processed. Once noted on the Comment Form the Company issued EOB's and checks for the interest/penalty due. Additionally, the amounts of interest/penalty appear to have been incorrectly calculated on some of the claims.

One claim was in the sample of denied claims reviewed for processing. Benefits were denied for lack of requested additional information on March 6, 2003. The claim was adjusted on April 9, 2003, forty-one (41) days after electronically receiving the requested information. Late payment interest was calculated incorrectly as a result of using the amount billed, $265.00, instead of the amount paid of $147.50. This resulted in an overpayment of $ .33¢ in interest.

Recommendation No. 33:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that in compliance with Colorado insurance law, late payment interest/penalties are paid and calculated correctly in all applicable instances.

In the Market Conduct examination for calendar year 2000, the Company was previously cited for failure to pay late payment interest and penalties as required by Colorado insurance law. The violation resulted in Recommendation # 44, that the Company establish procedures to ensure that, in compliance with Colorado insurance law, interest is paid on all clean electronically received claims not paid within thirty (30) days, all clean non-electronically received claims not paid within forty-five (45) days, and that a penalty is paid on the ninety-first day for all claims that remain unresolved after ninety (90) days. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C. R. S.

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